INDIANA INITIAL REFUGEE HEALTH ASSESSMENT

State Form 53700 (7-08)
Indiana State Department of Health

Information submitted on this form is confidential pursuant to IC 16-41-8-1.

***Instructions are attached to the back of this form*.**

Return completed form, preferably within thirty (30) days of U.S. date of arrival, to address at the bottom of this form.

Name *(last, first, middle)*:_____ Arrival Status*:☐R ☐A ☐VT ☐P ☐CH ☐2
Date of Birth *(month, day, year)*:_____ Gender: _____
Alien or Visa Registration number:_____ Volag: _____
U.S. Arrival Date *(month, day, year)*:_____ Country of Birth: _____
TB Class: ☐B1 ☐B2 ☐B3/Other ☐No Class Country before USA:_____&
Date of First Clinic Visit for Screening *(month, day, year)*: ____/____/____ Length of time there:_____

Immunization Record: Review overseas medical exam (DS-2053), medical history (DS-3026), chest x-ray (DS-3024), and vaccination (DS-3025) if available and document immunization dates. For measles, mumps, rubella, and varicella: indicate if there is lab evidence of immunity; if so, immunizations are not needed against that particular disease. For all other immunizations: update series, or begin primary series if no immunization dates are found. (*Fill in table below or attach immunization record from CHIRP.)* ☐***Overseas immunizations done***

Vaccine-Preventable Disease/ Immunization	'I' if there is lab evidence of immunity; immunization not needed	Immunization Date(s)					
		Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Measles							
Mumps							
Rubella							
Varicella (VZV)							
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT)							
Diphtheria-Tetanus (Td, Tdap)							
Polio (IPV, OPV)							
Hepatitis B (HBV)							
Haemophilus influenzae type b (Hib)							
Hepatitis A							
Influenza							
Pneumococcal							
BCG ☐ Yes-Date(s)_____ ☐ No ☐ Unknown							

Tuberculosis Screening:

Tuberculin Skin Test (TST)
Date given: _____read_____
____ mm Induration (not redness)
☐ Past history of positive TST
☐ Given, not read
☐ Declined test
☐ Not done

IGRA Test: date_____
Type_____
☐ Positive
☐ Negative
☐ Indeterminate
☐ Not done

Chest X-Ray – done in U.S.
(If TST or INFγ positive, Class B, or symptomatic)
☐ Normal
☐ Abnormal, stable, old or healed TB
☐ Abnormal, cavitary
☐ Abnormal, non-cavitary, consistent with active TB
☐ Abnormal, not consistent with active TB
☐ Pending
☐ Declined CXR
☐ Not done

Diagnosis
(must check one)
☐No TB infection or disease
☐ Latent TB Infection (LTBI)*
☐ Old, healed not prev. Tx TB*
☐ Old, healed prev. Tx TB
☐ Active TB disease – (suspected or confirmed)*
☐ Pending
☐ Incomplete eval., lost to F/U
*Complete TB treatment section

Treatment
(for TB disease or LTBI)
Start Date: ___/____/____
or Reason for not treating
☐ Completed Tx overseas
☐ Declined treatment
☐ Medically contraindicated
☐ Moved out of IN
☐ Lost to follow-up
☐ Further eval. pending
☐ Other: _____

TB treatment follow-up clinic if not the same as screening clinic:_____

Hepatitis B Screening:

1. Anti-HBs *(check one)* ☐ Negative ☐ Positive; *Note if positive, patient is immune.* ☐ Indeterminate ☐ Results pending
2. HBsAg *(check one)* ☐ Negative ☐ Positive* ☐ Indeterminate ☐ Results pending

**Note: if positive HBsAg, patient is infected with HBV and infectious to contacts. It is especially important to screen all household contacts.*

If positive HBsAg, were all household contacts screened? ☐ Yes → were all susceptibles started on vaccine? ___Yes ___No
☐ Contacts not screened → why not? _____

3. Anti-HBc *(check one)* ☐ Negative ☐ Positive ☐ Results pending ☐ Not done

Please turn the page for more tests →

Alien or Visa Registration number _____

Sexually Transmitted Infections: *(check one for each of the following)*

1. Syphilis ☐ Negative ☐ Positive; treated: ___yes ___no ☐ Results pending ☐ Not done, why not?_____
2. Gonorrhea ☐ Negative ☐ Positive; treated: ___yes ___no ☐ Results pending ☐ Not done, why not?_____
3. Chlamydia ☐ Negative ☐ Positive; treated: ___yes ___no ☐ Results pending ☐ Not done, why not?_____
4. HIV ☐ Negative ☐ Positive; referred to specialist? ___yes ___no ☐ Not done, why not?_____
5. Other, specify: _____ ☐ Negative ☐ Positive; treated: ___yes ___no ☐ Results pending

Intestinal Parasite Screening:

Was screening for parasites done? *(check one)*

- ☐ Not screened for parasites; why not? _____
- ☐ Screened, results pending
- ☐ Screened, no parasites found
- ☐ Screened, non-pathogenic parasites found
- ☐ Screened, pathogenic parasite(s) found (*check all that apply)*:

☐ Ascaris	Treated?	☐ Yes	☐ No	☐ Paragonimus	Treated?	☐ Yes	☐ No
☐ Clonorchis	Treated?	☐ Yes	☐ No	☐ Schistosoma	Treated?	☐ Yes	☐ No
☐ Entamoeba histolytica	Treated?	☐ Yes	☐ No	☐ Strongyloides	Treated?	☐ Yes	☐ No
☐ Giardia	Treated?	☐ Yes	☐ No	☐ Trichuris	Treated?	☐ Yes	☐ No
☐ Hookworm	Treated?	☐ Yes	☐ No	☐ Other *(specify)*: _____	Treated?	☐ Yes	☐ No
If not treated, why not?							

CBC with differential done? ☐ Yes ☐ No

If yes, was Eosinophilia present? ☐ Yes ☐ No ☐ Results pending

If yes, was further evaluation done? ☐ Yes ☐ No

Currently Pregnant *(check one)*:

☐ Yes ☐ No ☐ No test done

Please fill in for all refugees:

HEMOGLOBIN	HEMATOCRIT	LEAD (only for <6 yrs old)
	%	

Height_____ Weight_____ B/P_____

Malaria Screening *(check one)*:

- ☐ Not screened for malaria; (e.g., No symptoms and history not suspicious of malaria)
- ☐ Screened, results pending
- ☐ Screened, no malaria species found in blood smears
- ☐ Screened, malaria species found *(please specify)*: _____

If malaria species found: Treated? ☐ Yes ☐ No; Referred for malaria treatment? ☐ Yes ☐ No

If referred for malaria treatment, specify physician/clinic:_____

Referrals *(check all that apply)*:

☐ Primary Care Provider	☐ Dental	☐ Vision
☐ Mental Health	☐ Hearing	☐ Family Planning
☐ WIC	☐ Dermatology	☐ Public Health Nurse (PHN)
☐ GI	☐ OB/GYN	☐ Pediatrics
☐ General Medicine	☐ Endocrinology	☐ Urology
☐ Ear, Nose & Throat (ENT)	☐ Family Practice	☐ Neurology
☐ Hematology	☐ Other Referral _____	

Interpreter needed: ☐ Yes, language(s) needed: _____ ☐ No

Note: Fill out the Indiana Refugee Health Assessment Form indicating the results of the tests listed on this form and return to the local public health department noted below within thirty (30) days of receipt. For more information, contact the TB/Refugee Health Program, Indiana State Department of Health at: (317) 233-1321.

Screening Clinic _____ Physician/PA/NP/RN (Last)_____(First)_____
(please circle)

Address _____ City _____ State _____ Zip _____

Phone ( ) _____ Fax ( ) _____ Date screening completed _____/_____/_____

Name/title person completing form _____ ***MAIL OR FAX TO YOUR LOCAL HEALTH DEPARTMENT ADDRESS BELOW:***

Indiana State Department of Health

Indiana State Department of Health Initial Communicable Disease Health Screening Tests

***R=Refugee A=Asylee VT=Victim of Trafficking P=Parolee CH=Cuban or Haitian 2=Secondary**

Disease or Condition	Screening Recommendations
Immunizations	Assess and update immunizations for each individual. For measles, mumps, rubella, and varicella: indicate if there is lab evidence of immunity; if so, immunizations are not needed against that particular disease. For all other immunizations: update series, or begin primary series if no immunization dates are found. If you need assistance translating immunization records or determining needed immunizations, go to www.cdc.gov and search "Immunization Toolbox." Always update the personal immunization record card.
Tuberculosis (TB)	Perform a tuberculin skin test (TST) or IGRA Test (QuantiFERON Gold → QFT-G or T-Spot) for all individuals regardless of BCG history, unless documented previous positive test. Pregnancy is not a medical contraindication for TST testing or for treatment of active or latent TB. TST administered prior to 6 months of age may yield false negative results. A chest x-ray should be performed for all individuals with a positive TST or QFT test. A chest x-ray should also be performed regardless of TST results for: •those with a TB Class A or B designation from overseas exam, and •those who have symptoms compatible with TB disease.
Hepatitis B	Administer a hepatitis B screening panel including hepatitis B surface antigen (HBsAg), hepatitis B surface antibody (anti-HBs), and hepatitis B core antibody (anti-HBc) to all adults and children. Vaccinate previously unvaccinated and susceptible children, 0-18 years of age. Refer all persons with chronic HBV infection for additional ongoing medical evaluation. Vaccinate susceptible adults at increased risk for HBV infection.
Intestinal Parasites	Evaluate for eosinophilia by obtaining a CBC with differential and conduct stool examinations for ova and parasites; two stool specimens should be obtained more than twenty-four (24) hours apart. If parasites are identified, one stool specimen should be submitted 2-3 weeks after completion of therapy to determine response to treatment. Eosinophilia requires further evaluation for pathogenic parasites, even with two negative screening stool examinations.
Sexually Transmitted Infections	Screen for syphilis by administering VDRL or RPR. Confirm positive VDRL or RPR by FTA-ABS/MHATP or other confirmatory test. Repeat VDRL/FTA in two (2) weeks if lesions typical of primary syphilis are noted and person is sero-negative on initial screening. Use your clinical judgment to screen for chlamydia and gonorrhea using urine testing if possible. Screen for HIV and other STDs if indicated by self-report or endemicity in homeland.
Malaria	Screen those refugees who present with symptoms suspicious of malaria. For asymptomatic refugees from highly endemic areas, i.e., sub-Saharan Africa, screen or presumptively treat if no documented pre-departure therapy (note contraindications for pregnant or lactating women and children < 5 kg).
Lead	Venous blood lead level (BLL) screening is recommended for all refugee children under six (6) years. An elevated blood lead test is a result >=10ug /dl of blood. Depending on blood lead level, follow-up testing and appropriate management may be needed.

Other Recommended Health Issues to Consider

Health Problems	Screening
Hematologic disorders (eosinophilia, anemia, microcytosis), dental caries, nutritional deficiencies, thyroid disease, otorhinologic and ophthalmologic problems, history of trauma, dermatologic abnormalities.	CBC, serum chemistry profiles, urinalysis, height, weight, vision and hearing evaluation and blood pressure. Assess mental health needs (e.g., headaches, nightmares, depression). Refer to other health resources as needed.

Information on this form is collected for the Indiana State Department of Health (ISDH), by authority of Section 412(c)(3) of the Immigration and Nationality Act as amended by the Refugee Act of 1980. This assessment form follows the guidelines for medical screening (State Letter 95-37) developed by the Office of Refugee Resettlement (ORR), in collaboration with the Public Health Service (PHS), the Office of Refugee Health (ORH) and the Division of Quarantine, the Center for Disease Control and Prevention (CDC).

For more information contact:
TB/Refugee Health Program, Indiana State Department of Health
2 North Meridian St. 6-A, Indianapolis, IN 46204
(317) 233-1321 www.in.gov/isdh